SECTIONS 2 and 3:

CERTIFIED NURSE- MIDWIFE SERVICES

and

BIRTHING CENTER SERVICES

SECTION 2

CERTIFIED NURSE- MIDWIFE SERVICES

Table of Contents

1 GENERAL POLICY

Services of a Certified Registered Nurse-Midwife are provided to women eligible for or receiving Medicaid. The services are available to the extent that the nurse-midwife is authorized to practice under state law or regulation at Utah Code Annotated Title 58-44a. Direct reimbursement is available to the midwife as a payment option.

(Authority: Social Security Act 1891(gg) and 42 CFR 440.165

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed health care plan, such as a health maintenance organization (HMO), must receive all health care services, including medical supplies, through that plan. Refer to SECTION 1 of this manual, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs with which Medicaid has a contract to provide health care services is included as an attachment to the provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to what plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Billing

Nurse-Midwife services may be billed electronically or on paper, using the CMS-1500 claim format. Instructions for completing a paper HCFA-1500 claim form are included with this manual.

1 - 4 Definitions

A Certified Registered Nurse-Midwife (CNM) is a registered professional nurse who:

- Is currently licensed to practice in the state as a registered professional nurse;
- Is legally authorized by the state or regulations to practice as a nurse-midwife; and
- Has completed a program of study and clinical experience for nurse midwives, as specified by the state.

Nurse-Midwife services are services within the scope of practice authorized by state law for the nurse-midwife to include care for women during the maternity cycle and care for women's health problems beyond the maternity cycle. Services also include care for the infant through the first year of life.

2 LIMITATIONS

Certified Registered Nurse Midwives must work within their scope of licensure and in association with obstetrician/gynecologists or other physicians to whom they refer patients with high risk conditions or complications.

A. Emergency only clients - services for labor and delivery

Only labor and delivery codes are billable for an individual with an Emergency Services only Medicaid Identification Card. Other maternity care services (prenatal and postpartum) are not payable for an emergency only client. A Certified Registered Nurse-Midwife may be reimbursed for a delivery described by the following procedure code: 59409, Vaginal delivery only, with or without forceps.

For more information on the Emergency Services Program, refer to SECTION 1, General Information.

3 NON COVERED SERVICES

Medicaid does not cover certified registered nurse-midwife services in the following situations:

Services not specifically defined under the Medicaid scope of service are not covered, even though in other settings, the nurse-midwife may perform them.

1. Infertility diagnosis or therapy is not a covered Medicaid service.

2. Pre-pregnancy counseling is not a covered Medicaid service. It is not well defined and suggests prevention or education which are not general covered Medicaid services.

3. Pap smear is not a separate billable service, but is considered as part of an office call. The laboratory completing the service bills for the service.

4. Problems encountered during pregnancy must not be billed as separate services unless they are severe, unusual complications and require specific separate therapy which can be coded with a specific diagnosis code.

5. PMS is a very controversial diagnosis and is not considered a covered service for Medicaid.

6. Routine, preventive medicine type services are not covered. All office calls must be for a specific, identifiable service in relation to a medical need which can be coded by an appropriate ICD-9-CM diagnosis code.

7. Consultations, especially where risk to a patient is involved, is a physician service and not billable by the CNM.

4 COVERED SERVICES

Ambulatory, non-institutional type services directed toward management of health care for women and infants are covered services for the CNM. Some limited inpatient services, related to labor and delivery are covered if authorized in hospital policy. CPT codes will be used by the CNM to code and bill for services provided. To account for program utilization and differentiate between CNM services and physician services, editing will be done with the designated provider type.

Office Visits (New Patient)

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- an expanded problem focused history
- an expanded problem focused examination;
- straightforward medical decision making.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a detailed history;
- a detailed examination; and
- medical decision making of low complexity.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Office Visits (New Patient)

99431 History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)

99435 History and examination of the normal newborn infant, including the preparation of medical records. (This code should only be used for newborns assessed and discharged from the hospital or birthing room on the same date.)

Office Visits (Established Patients)

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- a problem focused history;
- a problem focused examination;
- straightforward medical decision making.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- an expanded problem focused history;
- an expanded problem focused examination;
- medical decision making of low complexity.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- a detailed history;
- a detailed examination;
- medical decision making of moderate complexity.

Procedures

The following procedures are suggested as appropriate services for nurse midwives to provide in their practice beyond maternity care.

58300 IUD insert, including office call

J7300 Supply of IUD. Bill in conjunction with office call for placement of device.

58301 IUD removal
For Medicaid, this includes the office call

11975 Norplant insertion (office call)

11976 Norplant removal
For Medicaid, this includes the office call.

17110 Destruction by any method of flat warts, molluscum contagiosum, or milia; up to 14 lesions

57170 Diaphragm or cervical cap fitting
For Medicaid, this includes the office call.

90782 Therapeutic or diagnostic injection, subQ or IM

Medicaid policy: This code for injection cannot be billed in addition to an office call. If no office call is billed, this code may be used in addition to the code for the specific medication used. The combination of office call, therapeutic injection and medication code are prohibited. Only two of the three codes can be used at one time.

Ultrasound

76815 Ultrasound, pregnant uterus, real time with image documentation; limited (fetal heart beat, placental location, fetal position, and/or qualitative amniotic fluid volume), one or more fetuses.)

Medications and Supplies

J3490 Unclassified drugs
(Must specify exact drug) (Priced by report)

A4260 Contraceptive capsule system and supply

Laboratory Procedures

Laboratory procedures must be provided under CLIA guidelines, and based on status of the laboratory and the certification approved for the laboratory within the office.

Medicaid policy for laboratory services states that the laboratory performing the test must bill Medicaid directly for the service. A provider cannot send a specimen to a laboratory, bill Medicaid for the test, and pay the laboratory.

Coding for Newborn Screening

Newborn screening (36) tests sponsored through the state laboratory are covered under the hospital DRG. Sometimes the infant is born outside of the hospital. The code **S3620 submitted with the BL modifier** is to be used by certified nurse midwives or clinics to bill for the state laboratory newborn screening kit when the procedure is completed through them instead of the hospital. The state laboratory newborn screening kit code includes the initial lab tests and a followup test about two weeks from birth. The venipuncture code may be billed in addition to S3620 - BL.

Diagnosis Codes -- ICD-9-CM

The following diagnosis codes are suggested as appropriate for the services provided by certified registered Nurse Midwives. These codes could be coded as the reason for office visits outside of the maternity cycle.

Breast

611.72	Lump or mass in breast
611.0	Inflammatory disease of breast (mastitis)
V76.1	Screening for Neoplasm of breast.

Cervix

795.0	Abnormal pap smear
622.7	Cervical polyp
616.0	Cervicitis
622.1	Cervical dysplasia
V72.3	Gynecological examination (annual) (periodic)
	Screening for cervical cancer

Contraception

V25.09	Other contraceptive advice
V25.1	IUD insert
V25.42	IUD removal
V25.01	Prescription, oral contraceptives
V25.02	Initiation, other contraceptive methods
V25.41	Surveillance, oral contraceptive therapy
V25.40	Surveillance, all other contraceptive therapy

Menses

626.0	Amenorrhea
626.8	Dysfunctional uterine bleeding
625.3	Dysmenorrhea
626.2	Menorrhagia
626.6	Metrorrhagia
627.2	Menopausal symptoms
627.1	Postmenopausal bleeding

Ovary/Uterus

620.0	Cyst, ovarian
621.2	Endometrial hypertrophy
218.9	Fibroid uterus
618.1	Uterine prolapse

Pain

789.0	Abdominal pain
625.0	Dyspareunia
625.9	Pelvic pain

Pelvis

617.9	Endometriosis
789.3	Pelvic mass
614.9	PID, nonspecific

Urinary Tract

595.9	Cystitis
599.0	UTI

Vagina/Vulva

627.3	Atrophic
616.3	Bartholin cyst abscess
078.1	Condylomata
616.10	Vaginitis and Vulvovaginitis
616.10/079.8	Chlamydia
616.10/0.64.11	Herpes
112.1	Monilia
131.01	Trichomonas

General

The following diagnosis codes are suggested as appropriate for treatment frequently provided to women served by a midwife during or apart from pregnancy.

285.0	Anemia (Separate from pregnancy. Anemia associated with pregnancy does not warrant separate billing or payment.)
311	Depression
487	Flu
244.9	Hypothyroidism
272.9	Lipoid metabolism disorders
034.0	Strep Throat
465.9	Acute upper respiratory infection

Maternity Cycle Codes for Midwives

59400	Global Maternity Care
59425	Antepartum care only; 4 - 6 visits
59426	Antepartum care only; 7 or more visits
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery only, and postpartum care, monitoring, local blocks and/or episiotomy
59430	Postpartum care only (separate procedure)
T1017	Perinatal Care Coordination (per month)
H1000	Risk Assessment (low risk)
H1001	Risk Assessment (high risk)
S9496	Group Prenatal/Postnatal Education
H1004	Prenatal and Postnatal (enhanced services) Home Visits
99204-SB	Prenatal Assessment Visit (Initial visit only) To be used only when patient is referred immediately to a community provider, or lost to follow up because patient does not return.
99212-SB	Single Prenatal Visit(s) Other than initial visit Maximum of three visits after initial visit, development of a plan of care and up to three follow up visits. (Patient lost to follow up)

Services in a Free Standing Birthing Center

Code 59899 – Unlisted Procedure, Maternity care or delivery -- Facility Charge Only

Rural Services

Services performed in rural areas will be reimbursed at 12% higher than the regular fee for global maternity care. The higher fee is available only when the CNM practices or travels to the rural setting. Payment is not based on patient residence.

INDEX